TO THE HONORABLE
TIMOTHY M. KAINE
GOVERNOR OF VIRGINIA

FROM THE GOVERNOR'S
COMMISSION ON SEXUAL VIOLENCE

Report and Recommendations

November 2007

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EXECUTIVE SUMMARY

Governor Timothy M. Kaine established the Commission on Sexual Violence to identify and promote appropriate and uniform criminal justice responses to sexual violence, comprehensive services to victims and effective prevention initiatives (Executive Order 38, 2006, Appendix A, page 30). The 38-member Commission included representatives of state agencies, the General Assembly, advocates for victims of domestic and sexual violence, law enforcement, health professionals and survivors of sexual violence (Appendix B, page 32).

Sexual violence is a serious social problem in Virginia that impacts an estimated one in four females and one in eight males.[1] Young children experience the highest risk of sexual assault. A survey conducted by the Virginia Department of Health in 2003 revealed that 46% of female victims and 44% of male victims reported they were victimized before 13 years of age.[2] The primary perpetrators are individuals who are known by the victim.[3] Victims of sexual violence often experience a variety of physical and mental health issues, which often last for prolonged periods of time. The Virginia Sexual and Domestic Violence Action Alliance estimates an annual cost of at least $232 million to the Commonwealth.[4]

Commission members identified six priority issues that need to be addressed to improve the Commonwealth's ability to prevent sexual violence from occurring and to respond appropriately and effectively to help victims when it does occur:

- Inconsistent responses across law enforcement and health care systems
- Inadequate access to a quality continuum of care
- Insufficient public awareness
- Inadequate reporting
- Cultural acceptance of violence
- Inadequately trained personnel

The Commission developed 27 action recommendations for consideration to address the priorities identified by the Commission.

1 *Senate Document 18: Response to and Prevention of Sexual Assault in the Commonwealth of Virginia.* Virginia Department of Health. 2005.
2 Ibid.
3 "Bureau of Justice Statistics Crime Characteristics." US Department of Justice: Bureau of Justice Statistics. 22 Aug 2007. http://www.ojp.usdoj.gov/bjs/cvict_c.htm.
4 "A Report for Governor Kaine's Commission on Sexual Violence." Virginia Sexual and Domestic Violence Action Alliance. June 2007.

SEXUAL VIOLENCE AND ITS IMPACT

Sexual violence is a pervasive national problem that affects millions of Americans every year, whether they are victims, survivors or friends and family members of those assaulted.

In 2000, the Department of Justice conducted a national survey on violence against women that estimated that approximately one million rapes occurred in the United States in 1999 with an average of 2.9 rapes per female victim and 1.2 rapes per male victim.[5] A Virginia Department of Health (VDH) 2003 survey estimated that 27.6% of female Virginians over 18 years of age and 12.9% of men over 18 years of age are survivors of sexual assault.[6] Based on 2005 Census estimates, approximately 822,180 women and 368,174 men, or 1,190,354 Virginians, have experienced at least one sexual assault in their lifetime.[7] The Rape, Abuse, and Incest Nation Network (RAINN) estimates that someone in the United States is sexually assaulted every two and a half minutes.[8]

It is very difficult to establish a solid figure on sexual assault rates. Nationally, it is estimated that less than half of all sexual assaults are reported.[9] The VDH survey estimates that only 12% of the victims reported the assault to the police.[10] National phone surveys are limited by the number of individuals who are willing to identify themselves as people who have experienced sexual assault, and these surveys are limited to individuals who can be contacted by telephone. Phone surveys may be the most reliable data available on the issue, but these survey neglect to target the populations that may be most at risk of sexual violence: the homeless, those living in poverty, young children and people who are institutionalized.[11]

Young children are the most at risk of sexual assault, both nationally and in Virginia. In the 2003 VDH survey, "46% of female victims reported that they were victimized before 13 years of age and the vast majority of female victims (87%) reported that they were victimized before they were 18. Among males, 44% were victimized before 13 years and another 94% before 18 years of age."[12] In comparison to the Department of

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5 Tjaden, Patricia and Nancy Thoennes. *Full Report of the Prevalence, Incidence, and Consequences of Violence Against Women*, Department of Justice: National Institute of Justice, 11 Feb. 2005. http://www.ncjrs.gov/pdffiles1/nij/183781.pdf, page 13.

6 Virginia Department of Health. *Senate Document 18: Response to and Prevention of Sexual Assault in the Commonwealth of Virginia.* 2005. http://leg2.state.va.us/dls/h&sdocs.nsf/By+Year/SD182005/$file/SD18.pdf Presentation.

7 United States, Bureau of the US Census. "Virginia QuickFacts from the US Census Bureau." http://quickfacts.census.gov/qfd/states/51000.html .

8 "Statistics." Rape, Abuse, and Incest National Network (RAINN). http://www.rainn.org/statistics/index.html

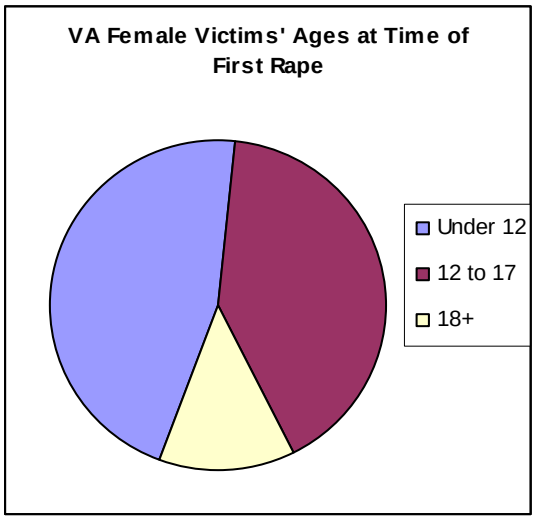
9 Rape, Abuse, and Incest National Network.

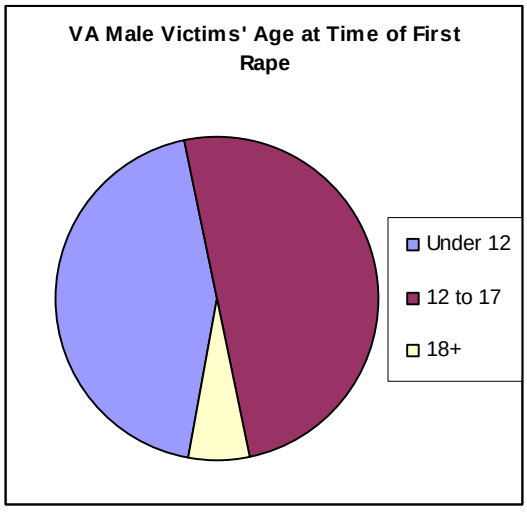
10 Virginia Department of Health presentation to Governor Kaine's Commission on Sexual Violence. Nov 30, 2006.

11 Tjaden, pg. 15.

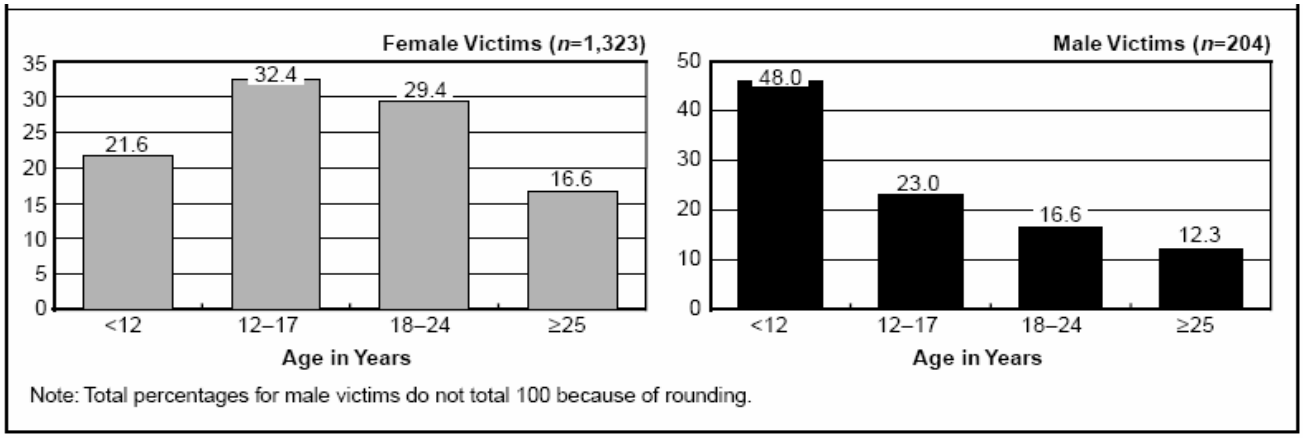
12 Virginia Department of Health. *Senate Document 18*.

Justice's national survey, Virginians who experience sexual assault are younger than the national average.[13]





Department of Justice's Statistics on Victim's Age at Time of First Rape and Victims' Gender[14]



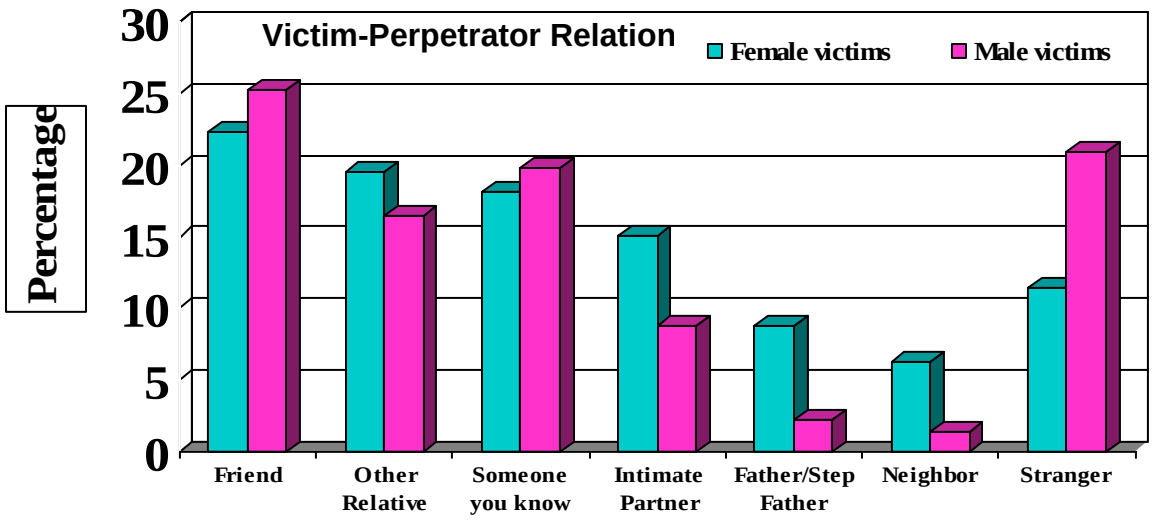
In addition to the initial victimization that these individuals undergo at a young age, experiencing sexual assault as a minor puts these individuals at an increased risk of future sexual assaults. According to the Department of Justice survey, women who were sexually assaulted as minors were twice as likely (18% likelihood) to be raped as adults as women who had not been raped as minors (9% likelihood).[15] However, even with these figures, one should still keep in mind those individuals who are more willing to disclose child sexual violence experiences are possibly more willing to discuss adult sexual violence experiences. Likewise, individuals who are unwilling to discuss

13 "Bureau of Justice Statistics Crime Characteristics." US Department of Justice: Bureau of Justice Statistics. 22 Aug 2007.
14 Tjaden, Exhibit 13, pg. 36.
15 Ibid, pg. 39.

childhood sexual violence experiences may also be unwilling to discuss adult sexual violence experiences.[16]

The primary perpetrators for both child and adult victims of sexual violence are individuals who are known by the victim. According to the 2004 National Crime Victimization Survey, seven out of ten incidences of sexual violence nationally were perpetrated by acquaintances, relatives or intimates.[17] In Virginia, that number is even higher with 89% of female victims and 79% of male victims knowing their attacker.[18] Of these victims, 20% of female victims and 25% of male victims experienced multiple sexual assaults by the same individual.[19]

As the following chart demonstrates, acquaintance rape (friend/someone you know/neighbor) comprises approximately 45% of female sexual assault cases and around the same percentage of male cases. Twenty-eight percent of cases of sexual violence against females are perpetrated by a relative and 15% by an intimate partner (including date, spouse, former spouse, boyfriend, girlfriend, etc). Of cases of sexual violence against males, 18% are perpetrated by relatives and slightly less than one in ten are perpetrated by intimate partners.



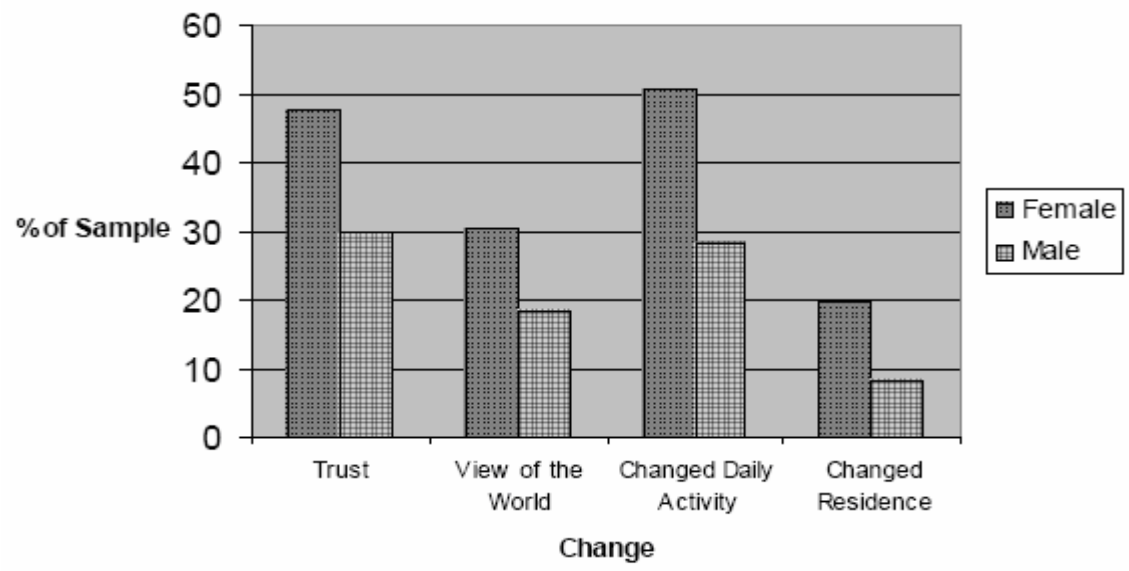
Many victims of sexual violence sustain injuries beyond those of the actual rape or sexual assault. Ten percent of female victims and slightly more than two percent of male victims sought medical care immediately after the incident. This is substantially lower than the national average (26%) of female victims seeking assistance immediately following an act of sexual violence.[21] The Department of Justice's national

16 Ibid, pg. 40.
17 "Bureau of Justice Statistics Crime Characteristics." US Department of Justice: Bureau of Justice Statistics. 22 Aug 2007.
18 Department of Health pg. 4.
19 Ibid, pg. v.
20 Department of Health Presentation
21 Department of Health pg. 11

survey reported that more than 30% of female victims over 18 years of age experienced a physical injury from the sexual assault and 16% of men who reported injury from their most recent victimization.[22] In addition to injuries such as scrapes, bruises, and broken bones, three percent of females surveyed in the VDH study reported becoming pregnant as a result of their rape and two percent of all applicable participants reported contracting a sexually transmitted infection as a result of their rape or sexual assault.[23]

Beyond physical injuries, victims and survivors of sexual violence must confront emotional injuries and behavioral effects of their experiences. Individuals who experienced sexual violence were more likely to abuse drugs and alcohol.[24] They were also likely to report having changed aspects of their lives as the result of the incident. The following chart demonstrates some of these changes, including changing residences, losing trust in others, changing one's view of the world and changing daily routine.

Percentage of Respondents Who Experienced Lifestyle Changes as the Result of Sexual Violence[25]



The impact of sexual violence on society is profound. Sexual violence rates have fallen with a relative consistency since the late 1990s; but, 2005 data reveals there were still more than 200,000 rapes, attempted rapes, and/or sexual assaults annually reported in the National Crime Victimization Survey.[26]

22 Tjaden pg. 49
23 Department of Health Presentation.
24 Department of Health Presentation.
25 Department of Health, pg. 5
26 Rape, Abuse, and Incest National Network.

METHODOLOGY AND APPROACH

The Commission defined sexual violence as:

A sex act completed or attempted against a victim's will or when a victim is unable to consent due to age, illness, disability or the influence of alcohol or other drugs. It may involve actual or threatened physical force, use of weapons, coercion, intimidation or pressure. Sexual violence also includes intentional and unwanted touching of a sexual nature against a victim's will or when a victim is unable to consent, as well as voyeurism, exposure to exhibitionism or undesired exposure to pornography.[27]

The Commission first convened on November 30, 2006 and Commission members reviewed information on the status of recommendations generated by past studies and commissions. A variety of speakers provided information documenting occurrences of sexual violence, both nationally and in Virginia, and statistical trends. Commission members identified critical issues and formed three committees to further explore those issues:

- Criminal Justice System Committee
- Prevention Committee
- Treatment and Intervention Committee

Commission members identified the committee of their choice and Commission Co-chairs identified state agency staff to support the Commission's activities. Additional individuals were identified and asked to serve as committee members to provide additional expertise and representation from different geographic regions of Virginia (Appendix D, page 35).

Four public input sessions were conducted in late January and early February 2007 in various regions of the state to gather information and recommendations for consideration by the Commission and its three committees. More than 230 individuals attended these sessions, representing a wide variety of communities and organizations. The results of the input sessions are summarized in the following section of this report.

Each committee met a minimum of three times between March and early June 2007. Committee members heard from a variety of expert speakers, thoroughly reviewed past recommendations and activities regarding state efforts to reduce sexual violence and meet victim needs, shared their individual expertise and perspectives and developed prioritized recommendations for the Commission's consideration.

The full Commission met on June 27, 2007 to review the recommendations developed by each of the committees and to hear public comment. Revised recommendations

27 Adapted from the" Injury Fact Book: 2001-2002," Centers for Disease Control. Atlanta.

were provided for final Commission review on September 27, 2007 and were finalized following additional public comment.

SUMMARY OF PUBLIC INPUT SESSIONS

All public input session comments were transcribed and grouped by Virginia Commonwealth University staff into similar categories to identify key messages that were consistently mentioned across all four input sessions. These messages are organized under four categories and summarized below:

- Crosscutting Issues
- Prevention
- Intervention and Treatment
- Criminal Justice System

Crosscutting Issues

COMMUNICATION AND COLLABORATION

Communities and regions that utilize coordinating councils, sexual violence task forces or other mechanisms that bring professionals together on a consistent, regular basis have better results in preventing and responding to sexual violence. Such mechanisms facilitate the sharing of information and coordination of responses.

Sexual Assault Response Teams (SART) or Multidisciplinary Teams (MDT) improve the ability of communities to effectively respond to victims of sexual violence. SARTs provide immediate response to reports of sexual assault and typically include a forensic nurse examiner, a community-based victim advocate and a law enforcement officer. Multidisciplinary teams are composed of individuals in the community who may deal with sexual assault victims in the course of their jobs, and typically include SART members.

The absence of coordinating councils and task forces, SARTs and MDTs contributes to the lack of consistent and effective responses in some communities. For more information on this issue, reference the Intervention and Treatment section.

Prevention

SECONDARY EDUCATION PROGRAMS

Sexual violence education programs provided in public schools are cited as effective prevention practices. Frequently mentioned programs for younger children include *Good Touch, Bad Touch* and *Hugs and Kisses*. Programs that educate both males and females and address developmentally appropriate issues, such as appropriate attitudes towards the opposite gender, are mentioned as best practices.

Numerous participants indicated that prevention education programs are not available in all public schools. Contributing factors cited for the reduction or absence of sexual violence prevention programs include absence of a clear link to Standards of Learning requirements, lack of support from school administrators and parents and a general reluctance to provide information relating to human sexuality.

The need to increase sexual violence prevention education in secondary schools was endorsed by participants in all sessions. Programs are recommended at the K-12 levels ranging from instruction regarding inappropriate touching for young children to ways of preventing date rape for older students.

Higher Education and Military Facilities

Numerous sexual violence prevention and awareness programs are available on the campuses of community colleges and public and private colleges and universities in Virginia. Prevention programs are also present on many military bases. The design of these programs reaches out to young adults to help them understand their role in preventing sexual violence and appropriate responses to victims.

Participants recommended that these programs be strengthened and expanded to reach more students and military personnel. Programs designed and provided for both males and females are essential. It was also recommended that campuses have dedicated and appropriately trained personnel to address sexual violence issues.

Public Awareness

Participants indicated the public is not sufficiently aware of how to prevent sexual violence and respond appropriately to victims. Cited factors include a reluctance to publicly discuss sexual behavior and a denial that the problem exists in their community.

A coordinated statewide multimedia public education campaign was recommended to help raise awareness about sexual violence issues. A general education campaign should include messages regarding the relationship between domestic and sexual violence as well as messages that will help change the attitude that violence is acceptable. The campaign should include messages designed to reach children, youth, parents, young adults and other segments of the society that might be at-risk.

Criminal Justice

Investigation of Reports of Sexual Violence

The way incidents of sexual violence are investigated by law enforcement varies among localities. Communities that received high marks for the way they conducted investigations had police departments or sheriff's offices that had specially trained individuals, usually assigned to special units, responsible for the investigation.

We heard from a number of individuals whose experience was less than positive. A theme common to all four regions, more pronounced in some than others, was that law

enforcement personnel often appeared to blame the victim for the incident. This occurred most often if the alleged perpetrator was known to the victim. Victim blaming also appeared when the complainant used alcohol or other drugs prior to the sexual assault.

There were reports of some localities in which police would not investigate a sexual violence report if the victim had used alcohol or if illegal drugs were involved. The use of polygraph tests on victims by law enforcement to check out their story before a full investigation was undertaken was also reported.

There appeared to be consensus among the input sessions that, at the very least, standardized, mandated training on interviewing victims, rape trauma syndrome and acquaintance rape is needed for law enforcement officers. This training should be conducted for patrol officers, new recruits and other first responders. Advanced training should be ongoing for those who are assigned to investigate sex crimes.

Several groups recommended consistent, statewide protocols and procedures for the investigation of incidents of sexual violence. This would minimize the disparities and differences in the treatment of victims in the Commonwealth.

SEXUAL ASSAULT NURSE EXAMINERS (SANE) AND FORENSIC NURSE EXAMINERS (FNE)

Overwhelmingly positive comments about the Sexual Assault Nurse Examiners (SANE) and Forensic Nurse Examiners (FNE) programs were heard consistently in all the input sessions. These specially-trained nurses conduct the medical exam of a victim in a forensically sound way, collecting and preserving evidence that can be used by law enforcement. These programs are most often found in large urban hospitals with active emergency rooms. Some SANE and FNE nurses are on-duty 24/7 and others are simply on-call.

Some programs have a victim advocate on-call who can be present to support a victim through the exam. The lack of standardized protocols in hospitals was reported as a barrier to consistently effective services. In hospitals that do not have an in-house advocate, the Health Insurance Portability and Accountability Act (HIPAA) has been a barrier to service. Some believe that HIPAA regulations do not allow hospital staff to contact a support person/advocate at Sexual Assault Crisis Centers or Victim/Witness Programs without the victim's express permission. However, it appears that a healthcare provider may contact allied professionals about a case and omit identifying information. For example, when a victim arrives at a hospital, the hospital can only communicate to a sexual assault crisis advocate that a sexual assault has occurred and that the victim is at the hospital seeking medical services. Only the victim can decide whether to seek services from that advocate and provide personally identifying information to the advocate.

Another recommendation that was overwhelmingly supported was increased funding for SANE/FNE programs so that victims in rural areas would have easier access to this service.

PHYSICAL EVIDENCE RECOVERY KITS (PERK)

At each of the input sessions, the issue of PERKs was discussed. These evidence kits are sometimes critical to the successful prosecution of a sex crime. However, in order for a PERK to be completed and paid for by the Commonwealth, victims must agree to contact law enforcement and prosecute the offender at the time of the exam. If victims do not agree to such a commitment, they must pay for the PERK themselves. Many participants at the input sessions felt that having to make this kind of decision was too much to require of a victim during a time of crisis. A recommendation was made several times to either allow or mandate that the state pay for PERKs without the victim committing to prosecution at the time of the exam.

At every public hearing, we heard comments that it often takes months to receive the results of PERK tests. The delays in receiving the PERK test results then leads to a delay in the investigation or prosecution of a case. The overwhelming recommendation was to reduce the time it takes for the state forensic lab to process PERK and DNA tests. Session participants specifically suggested the state hire more forensic lab technicians.

REPORTING AND UNDER-REPORTING OF SEXUAL VIOLENCE

In Virginia, there is a 24-hour statewide hotline and many local hotlines available for reporting of a sexual violence incident. A hotline is often the first place to receive a report of sexual violence. Victims can receive information, support, crisis intervention and referrals to needed short and long-term services. Although hotlines are one of the strengths of Virginia's system, insufficient funding prevents 24/7 staffing of all of the local hotlines to be staffed 24/7. This can delay reporting of sexual violence and delivery of available services.

Although Virginia has a good system through which sexual violence can be reported, some participants expressed concern that incidents of sexual violence go unreported for a variety of reasons. One of the reasons cited was the fear of a negative response by the community and criminal justice system. This belief is directly related to the previously stated issue of victim blaming. It is not uncommon for victims to already feel a variety of negative emotions such as shame, fear, embarrassment and self-recrimination. These feelings are often amplified by some communities and cultures.

Some victims do not report sexual violence for fear of reprisal or of being stigmatized by their family and community. Prison inmates and residents of other institutions often are revictimized if they report sexual violence. The mentally ill, illegal and legal immigrants, those who do not speak English and victims of same sex violence often find the barriers to reporting too high to overcome. At the input sessions we received more information about these barriers than any recommended solutions.

MANDATORY REPORTING

Comments about the mandatory reporting of sexual violence were not clear as to whether participants preferred reporting to law enforcement or to Child Protective

Services. Some people felt strongly that there should be enforcement of mandatory reporting by schools, churches and other organizations so offenders could not just resign from one position and then return to another position in the same or similar organization.

Others felt mandatory reporting could discourage reporting by children and youth to a trusted authority figure, such as a guidance counselor, for fear of having it reported to authorities or their parents. This could leave young victims feeling that there was no one to talk with and no one from whom they could receive support.

PROSECUTION

The comments we heard concerning the prosecution of sexual violence offenders were very similar to the comments about the investigation of alleged perpetrators. Localities that have specially trained prosecutors, who have sexual assault cases as their sole or major responsibility, were perceived to be more effective and more sensitive to victims.

The model of vertical prosecution, in which the same prosecutor handles the case from the first hearing through the final hearing, was reported to be the most victim-friendly.

Comments were made in several groups that prosecutors do not want to go forward with unwinnable cases. Cases in which there was no physical evidence, or in which the victim had used alcohol or other drugs were often deemed "unwinnable". Similar to comments about law enforcement, some people felt that there is a "victim-blaming" attitude among some prosecutors, especially in cases in which the victim knew the perpetrator.

There was some discussion about how data was collected and reported by Commonwealth's Attorneys. A suggestion was made that there should be a report card on prosecution – reporting how many cases were reported charged, prosecuted and the outcome.

Another recommendation consistent across these sessions was that trials should be scheduled, as close to the arrest as possible and that multiple continuances should be avoided. Another recommendation was that there should be timely notification of court hearings or continuances to victims and witnesses and that Court Watch programs, similar to those in place for cases of domestic violence and drunk driving, should be developed.

TRAINING FOR PROSECUTORS

We heard a number of comments that sexual violence cases were often assigned to the newest, least experienced prosecutors. One participant said in her locality cases were assigned to whoever "got the short straw". A consistent recommendation was that prosecutors receive specialized training in handling sexual violence cases, including information on the dynamics of familial sexual assault.

Intervention and Treatment

Sexual Assault Crisis Centers

The system of Sexual Assault Crisis Centers appears to be the heart of service delivery for victims of sexual violence. They often provide support advocacy for individual clients, support groups for survivors of sexual abuse, referrals to specialized services and accompaniment through the legal system. The consistent one-to-one relationship with an advocate is essential for victims as they go through the criminal justice and healing process.

The hotlines referenced earlier are usually housed and staffed by sexual assault crisis centers. Staff members from these centers often serve on local multidisciplinary teams that address local policies, protocols and system issues. Inconsistencies exist in the quality, hours and services provided. As one might expect, programs in rural areas were less likely to provide as many services or to be staffed for as many hours as centers in more populated areas. Several people recommended mandatory standardized protocols and level of services required for centers.

One frequent recommendation to correct theses inconsistencies was to increase the funding of the sexual assault centers. There were recommendations to provide programs that would focus on outreach into underserved populations such as the elderly, immigrants and males.

Victim/Witness Programs

In the public input sessions, Victim/Witness (V/W) programs were often mentioned alongside the Sexual Assault Centers. V/W programs provide support to victims through the investigation and trial by assisting with one-to-one support, education on the legal system, transportation, notification of court dates and assistance with receiving help from the Criminal Injuries Compensation Fund (CICF).

There were comments about the V/W programs similar to those about the Sexual Assault Crisis Centers. These included the lack of standardized services, hours and functions and even the lack of services in some areas.

We frequently heard that there should be a uniform set of services and standards across the Commonwealth so victims in all localities can have access to the same level of services.

Child Advocacy Centers

Child Advocacy Centers exist in several of Virginia's large, urban areas. These centers are one-stop operations for the treatment for child victims of sexual assault. They generally encompass medical exams, forensic interviews with law enforcement and child protective services and follow-up treatment in a child-friendly environment. Many participants praised these centers as the ideal way to handle cases of child sexual assault. Overwhelmingly, the creation of more Child Advocacy Centers was

among the recommendations at each of the four public input sessions. These centers are models of the multidisciplinary team approach that was discussed earlier under crosscutting issues.

HOTLINES

In the section "Reporting and Under-Reporting of Sexual Violence", hotline services were briefly mentioned. These Sexual Assault Hotlines are usually housed and staffed by the Sexual Assault Crisis Centers and are often the first point of contact between a victim and the system. Hotline staff provide crisis intervention, support and referral services and play a critical role in assisting victims with finding the resources and help they need. As with other services, the hours, the level of services and staff training are inconsistent around the state. There were no recommendations specific as to Sexual Assault Hotlines apart from the ones related to the Sexual Assault Crisis Centers.

TRANSPORTATION

Lack of transportation for victims to hospitals, counseling and other services continues to be a challenge in Virginia. The problem is found largely, but not exclusively, in rural areas. V/W and Sexual Assault Crisis Center staff and volunteers appear to be the primary providers of transportation for victims without their own transportation. Increased funding for these programs was the sole recommendation to alleviate this problem.

RECOMMENDATIONS FOR ACTION

The Commission's three committees identified 105 draft recommendations. Each committee worked diligently to identify recommendations that promised the greatest opportunity to prevent sexual violence from occurring and to respond effectively to meeting the needs of victims.

Twenty-eight prioritized recommendations were forwarded by the committees for Commission review. Twenty-seven recommendations are included in this final report. Each recommendation identifies specific actions to be taken and the agency or organization that could be tasked with coordination responsibility. The recommendations outlined on the following pages are organized by primary area of concern: criminal justice system, prevention and intervention and treatment.

RECOMMENDATIONS FOR ACTION

Criminal Justice System		
Recommendation	**Explanation**	**Cost & Comments**
1. Repeal *§18.2-66* of the *Code of Virginia,* which provides a defense to carnal knowledge for the subsequent marriage of a perpetrator to the 14 year-old female victim.	Marriage data compiled by VDH for the years 2001 through 2005 indicate that 3,233 marriages took place in Virginia for brides under the age of 17. Only 39 of those marriages involved a bride that was age 14 years (1.2%).	Minimal.
2. The Department of Criminal Justice Services (DCJS) and the Office of the Executive Secretary of the Virginia Supreme Court should coordinate the provision of ongoing information and training on child and adult sexual violence through continuing education programs. Training should include information on recognizing and accommodating the special needs and cultural attributes of victims of all ages, those who have disabilities and those who are not proficient in the English language.	DCJS currently provides training on the investigation and prosecution of child sexual abuse issues. The training is specific to child victims and is funded through the federal Children's Justice Act. DCJS collaborates with the Commonwealth's Attorneys' Services Council, Office of the Executive Secretary of the Supreme Court of Virginia, the Chiefs and Sherriff's Associations and local practitioners in developing training topics and agendas.	Recommendation would be to continue the training provided by DCJS and the Executive Office of the Supreme Court do. Grant funding for a sexual violence-training program coordinated by the Commonwealth's Attorneys Services Council is pending approval from the Criminal Justice Services Board.
3. Amend *§19.2-9.1 of the Code of Virginia* to prohibit law enforcement officers from asking or requiring a victim of an alleged sex offense to submit to a polygraph examination as a condition for proceeding with the investigation of such an offense.	The federal Violence Against Women Act (VAWA) of 2005 (H.R. 3402) prohibits law enforcement officers from asking or requiring a victim of an alleged sex offense to submit to a polygraph examination as a condition for proceeding with the investigation. Virginia has three years to comply with this requirement. If Virginia does not comply, the state will lose approximately $2.5 million in federal VAWA-STOP funds, and the state and several localities may lose up to $2 million in federal grants to encourage arrest policies. Currently, the *Code of Virginia* does not specifically contradict this	Loss of $4.5 million in federal funding if Virginia does not comply by January 5, 2009.

Criminal Justice System		
Recommendation	**Explanation**	**Cost & Comments**
	assurance, but it does not fully address it. The language of *§19.2-9.1* requires that victims must be informed in writing prior to an examination and gives them the option of refusing to take the test. It is recommended that *the Code of Virginia* be strengthened to prohibit the use of polygraph tests on victims of sexual violence. In 2004, DCJS conducted a survey of sexual Assault policies of law enforcement agencies. Seventy-two percent of respondents indicated that they sometimes performed polygraph exams on victims of sexual assault. Only 14.6% indicated that they *never* asked a victim to submit to a polygraph exam.	
4. Amend the *Code of Virginia* to establish a consistent gradient of penalties and sentencing for perpetrators of sexual violence against children of specified age groups. Gradients of punishment should be consistently applied for all relevant Code sections for the age groups of less than 13 years of age, 13 to less than 15 years of age and ages 15 to 17. The gradients of penalties and sentencing should be applied to parents, stepparents, grandparents and others in a custodial or supervisory relationship with the child.	Discrepancies currently exist concerning penalties and sentencing for aggravated sexual battery, felony sexual assault, taking indecent liberties with children and indecent liberties by persons in custodial or supervisory relationships. There is a need to create consistent in sentencing gradients based on victim age and the perpetrator relationship to the victim. Specifically, within the Code, there are conflicts between the two indecent liberties statutes. In *§18.2-370*, if a person proposes that a child engage in sexual behavior, it is a Class 5 felony. However, under *§ 18.2-370.1*, if a person engages in a similar act with a child, that person is guilty of a Class 6 felony. There is a need to enhance the punishments for engaging in criminal sexual conduct with a child. In addition, merging *18.2-370* and *18.2-370.1* into a single statue would ensure enhanced punishment across all of the acts included in one or both of the current statues by age and would base punishment on age and the perpetrator's relationship to the victim.	$400,000 – $600,000
5. Amend the *Code of Virginia* to require court personnel to enter protective	Approximately 12,000 protective orders are issued annually. VCIN provides a means of rapid communications for criminal justice	None

Criminal Justice System		
Recommendation	**Explanation**	**Cost & Comments**
orders for all civil abuse cases into the Virginia Crime Information Network (VCIN) within a specified time frame and to forward copies of said protective orders to the appropriate Commonwealth's Attorney when there is a collateral criminal prosecution. *(§ 16.1-253.1*).	agencies throughout the Commonwealth of Virginia. Entering protective orders into the system within a specified time frame will help ensure that law enforcement officers have access to up-to-date information in the field.	
6. The Office of the Executive Secretary of the Virginia Supreme Court should provide reimbursement for Physical Evidence Recovery Kits (PERK) for all victims of sexual violence regardless of whether or not the victim agrees to pursue prosecution at the time of the medical examination and/or police investigation.	The federal Violence Against Women Act of 2005 (H.R. 3402) prohibits states from requiring a victim of sexual assault to participate in the criminal justice system or cooperate with law enforcement in order to be provided with a *forensic medical exam*, reimbursement for charges incurred on account of such an exam, or both. Virginia has three years to comply with this requirement. If Virginia does not comply, the Commonwealth will lose more than $2.5 million dollars annually in federal grant funds. The *Code of Virginia*, *§19.2-165.1*, states that "all medical fees involved in the gathering of evidence for all criminal cases where medical evidence is necessary to establish a crime has occurred shall be paid by the Commonwealth out of the appropriation for criminal charges." The Supreme Court of Virginia is responsible for processing the payment of PERK examinations. The local Commonwealth's Attorneys authorize payment of a PERK examination by the Supreme Court of Virginia. To comply with the VAWA requirement, amendments to *§19.2-165.1* are necessary to assure that all PERKs conducted would be paid, without specific individual authorizations by the local Commonwealth's Attorney.	Loss of $2.5 million in federal funding if Virginia does not comply by January 5, 2009. The required Code changes for compliance with federal law will create an upward swing in the number of PERKs reimbursed throughout the Commonwealth. However, there is no way to accurately estimate how many additional PERKs the state will need to reimburse. There could be any where from a 10 to 50% increase in PERK reimbursements.

Criminal Justice System		
Recommendation	**Explanation**	**Cost & Comments**
7. The Compensation Board should conduct a study to determine the staffing needs and fiscal impact of requiring Commonwealth's Attorneys to prosecute all sexual violence misdemeanors.	The majority of Commonwealth's Attorneys attempt to prosecute all sexual violence misdemeanors, but do not always have adequate staff resources to do so. A study is needed to determine the specific staffing needs to permit prosecution of all sexual violence misdemeanors.	Minimal - Work can be accomplished with existing staff.
8. Conduct a comprehensive review of the *Code of Virginia's* sex crime statutes, including the implications of using gradients of penalties to obtain consistency across statues.	A comprehensive review of Virginia's crime statues has not occurred for a number of years. A comprehensive review would help ensure that Virginia's statutes are uniform and consistent.	Minimal - Work can be accomplished with existing staff.
9. Amend the *Code of Virginia* to require local and state law enforcement agencies to create a written policy on response to and investigation of sexual assault incidents. DCJS should be requested to collaborate with the Virginia Law Enforcement Professional Standards Commission to assure that a written policy for the investigation and handling of sexual assault cases is required of any Virginia law enforcement agency seeking accreditation through the Commission. Any adopted written policy should take into consideration practices that should be implemented to address the needs of victims of all ages, those who have disabilities or those who are not proficient in the English language.	Law enforcement agencies are currently mandated to have policies guiding responses to incidents of domestic violence. All law enforcement agencies should have policies in place for incidents of sexual violence against children and adults. There are nearly 400 law enforcement agencies in Virginia, whose policies and procedures are generally established within each agency. While some model policy exists for their guidance, its use is not required, nor is the existence of such written policy required. This creates the potential and the reality for widely differing approaches to the handling of similar incidents from one jurisdiction to another. DCJS has provided a manual of well-researched sample directives addressing many of the most important areas of law enforcement policy and practice. Most of Virginia's smaller and medium-sized law enforcement agencies have come to look upon this resource as their best guide to solid, contemporary policy and practice.	None

Prevention		
Recommendation	**Explanation**	**Cost & Comments**
10. The State Council for Higher Education in Virginia (SCHEV) should establish a position to promote sexual violence prevention on campuses and compile an annual report on incidence, prevalence, policy, prevention education and areas for improvement. SCHEV should help formulate statewide polices to address sexual harassment, sexual violence and inappropriate sexual relations between higher education faculty, students and staff. SCHEV should also help formulate uniform policies requiring sexual violence prevention programs that address approaches beyond risk reduction for all students.	In 1991, the General Assembly requested that SCHEV study sexual assault and rape on Virginia's college and university campuses (SJR194). SCHEV surveyed campus administrators and students and submitted recommendations in Senate Document 17 to the General Assembly for the 1992 session. As a result of this study, grant funding was obtained for SCHEV to continue working with campuses as they develop their programs over the following three years. SCHEV guided the development of campus policy and prevention efforts, conducted additional surveys and sponsored regional meetings and statewide conferences. The agency also developed and implemented comprehensive training for campus judicial officers who adjudicated allegations of sexual violence on campus. Virginia led the nation in these efforts; however this grant funding ended in 1995. Campus administrators and staff independently continued to address sexual violence, but statewide leadership remains necessary. Policy revision, technical support, training and studies to determine the status and needs concerning the issue are some areas requiring attention.	$150,000 per year
11. Virginia should adopt and adapt the Domestic Violence Prevention Enhancement and Leadership through Alliances (DELTA) model process to guide sexual violence primary prevention programs. The General Assembly should provide funding for the development of these strong community-based partnerships.	Virginia is one of 14 states selected to implement the DELTA project through the Centers for Disease Control and Prevention. This project is in its fifth year and has been very successful in bringing together diverse members of local communities to plan, implement and evaluate projects designed to prevent domestic violence before it starts, particularly in populations at high-risk for perpetrating violence. To fully fund these seven current local DELTA communities and statewide infrastructure will cost the Commonwealth of Virginia $288,000 annually.	$288,000 per year

Prevention		
Recommendation	**Explanation**	**Cost & Comments**
12. VDH should coordinate the development and implementation of a public education program and branded media campaign on the prevention of sexual violence across the life cycle, which emphasizes the importance of all adults taking responsibility for preventing its occurrence.	Many individuals' hold beliefs about sexual violence that are false and promote the acceptance of sexual violence. These include the idea that sexual violence happens only to women, that only strangers commit sexual assaults and that only certain women will be victims of sexual violence. Virginia has implemented numerous successful campaigns with the intent of identifying victims and linking them with services. However, there is no campaign to address the prevention of violence across the lifespan. This proposal would: ▪ Increase public awareness about the problem of sexual violence; ▪ Provide information and educational resources for individual and professionals on how to respond to sexual violence; ▪ Provide individuals and communities the tools needed to prevent sexual violence before it occurs (this primary prevention must include both women and men as part of the solution to ending sexual violence); and, ▪ Reduce the incidence of sexual violence across the life cycle.	$640,000
13. The Commonwealth should provide resources to enable VDH to research and compile statewide child sexual abuse, sexual assault, dating violence, intimate partner violence and elder abuse incidence data across all age groups. This research should document short and long-term costs of such abuse and savings to the Commonwealth when abuse is prevented or victims are provided timely	Currently, the only data gathered on the incidence of sexual violence is from police reports of a violent crime, founded cases of child sexual abuse and the number of victims receiving services from sexual assault crisis centers. These data sources do not accurately reflect the incidence of sexual violence, as research shows that only 10-40% of victims report their victimization. VDH should conduct an annual sexual violence surveillance survey and an annual research project dedicated to finding the incidence and prevalence of sexual violence in a selected marginalized population. This data is currently lacking in Virginia and is necessary to accurately	$295,000

Prevention		
Recommendation	**Explanation**	**Cost & Comments**
services.	target populations for intervention and prevention programming. If this recommendation were implemented fully, Virginia would be able to: ▪ Accurately identify the victims and perpetrators of sexual violence are; ▪ Align prevention strategies and financial resources with the above data; and, ▪ Monitor the outcomes of prevention strategies by reviewing the annual incidence data.	
14. The Virginia Employment Commission (VEC) should identify, compile, publish and disseminate effective sexual violence prevention and intervention strategies within the workplace.	Places of employment offer a convenient and effective venue for providing adults information on the prevention of sexual violence, both within the workplace and the broader community. Currently, materials are disseminated to employees and employers on how to prevent and respond to acts of sexual harassment in the workplace. The VEC has a standard policy and procedure available to their employers and customers in response to acts of sexual harassment in the workplace. Additionally, many VEC offices across the state have pamphlets and brochures about sexual violence, including numbers to call for emotional support and criminal prosecution.	Minimal - Work can be accomplished with existing staff.
15. The Governor's Office for Substance Abuse Prevention (GOSAP) should develop and implement a statewide youth risk behavior survey that includes questions relating to sexual violence victimization.	The greatest impediment to practicing sound prevention in Virginia is the lack of a consistent survey of alcohol, drug and violence-related behaviors and perceptions of youth in each city and county throughout the Commonwealth. This vital information currently is captured only at the state (or Health Planning Region) level. Governor Kaine, through Executive Directive 4, charged the GOSAP Collaborative with researching and determining the feasibility of a statewide survey of youth to monitor attitudes, perceptions and	Minimal - Work can be accomplished with existing staff.

Prevention		
Recommendation	**Explanation**	**Cost & Comments**
	behaviors that contribute to the health and well-being of Virginia's youth, families, schools and communities.	
16. The General Assembly should support school-based initiatives that demonstrate the ability to meet Family Life Education (FLE) standards related to child sexual abuse, dating violence and sexual violence prevention in culturally appropriate ways. FLE Standards of Learning should reflect the latest data, trends and evidenced-based practices.	The current descriptions of the FLE Standards of Learning do not reflect current best practices and approaches.	Minimal
17. The Department of Education should develop model policies and provide education and guidance on how mandatory reporters identify and refer suspected instances of child sexual violence to the appropriate investigative authority.	The *Code of Virginia*, § 63.2-1509 specifically names the teacher or other person employed in a public or private school, kindergarten or nursery school as a mandated reporter. *§22.1-298.8* requires teachers to complete training on child abuse and neglect as part of the licensure process. Training is currently provided personnel who are considered mandatory reporters. However, it is somewhat unclear to whom a mandatory reporter is required to report to. In some localities, teachers report suspected cases of child abuse to the principal or school administrator, who then investigates whether to report the case to Department of Social Services. Guidance is needed on whether principals should be performing these investigations.	None – Could be accomplished through Superintendent's Memorandum

Treatment and Intervention		
Recommendation	**Explanation**	**Cost & Comments**
18. The Secretary of Health and Human Resources, in coordination with the Secretary of Public Safety, should convene a multi-disciplinary advisory group to develop a statewide standard of care for healthcare professionals when responding to sexual violence. Membership shall include, but not be limited to, representatives from the healthcare industry, the insurance industry, hospital associations, law enforcement, survivors, the Virginia Supreme Court, Criminal Injuries Compensation Fund, victim services organizations and others representing the diversity of cultures across the Commonwealth.	Convenient access to forensic exams and appropriate medical care in hospital emergency departments results in a better quality of care for victims of sexual violence. Many Virginia localities do not have appropriate medical personnel available and victims are sometimes transported considerable distances to receive forensic exams, adding to the trauma of the event. A statewide standard of care would help ensure the unique needs of sexual violence victims are met. The goal of this task force would be to ensure that each victim of sexual violence has reasonable access to a competent forensic exam and appropriate health care. The Virginia Sexual and Domestic Violence Action Alliance (VSDVAA) and the Secretaries of Public Safety and Health and Human Resources earlier this month entered into a cooperative agreement to develop a standard of care for healthcare providers for the acute responses to sexual violence. The Action Alliance, in partnership with the Virginia Chapter of the International Association of Forensic Nurses, is submitting a grant proposal to support a statewide initiative to develop a standard of health care for sexual violence victims, including access to forensic nurse examiners.	Grant funding is pending approval from the Criminal Justice Services Board, which meets December 13, 2007.
19. The Commonwealth should continue to fund the development and maintenance of local Child Advocacy Centers (CACs) and to provide a child friendly environment, where possible. Services should be delivered through a coordinated effort among agencies and one agency should assume the role of case manager in coordination with local SARTs, where available. Centers	CACs are facility-based programs that help coordinate the investigation, treatment and prosecution of child abuse cases. Recognizing that child abuse is a multifaceted problem, CACs involve multidisciplinary teams of professionals—child protective services, victim advocacy services, medical and mental health agencies, law enforcement and prosecution—that provide a continuum of services to victims and non-offending family members. Currently, there are 16 CAC programs, all of which are either accredited or working towards accreditation with the National	$1 million each year for FY 2008 and FY 2009

Treatment and Intervention		
Recommendation	**Explanation**	**Cost & Comments**
receiving funding should collaborate with the National Children's Alliance.	Children's Alliance. While the number of CACs has increased, there are still communities that do not have access to a Center. As more programs are added, funding will be stretched to maintain established programs. Currently, the Virginia General Assembly has appropriated $1 million annually of general funds; however, this appropriation will run out at the end of 2008. During the first six months of 2006, CACs across Virginia reported serving 1,544 victims of child abuse and neglect. In terms of age ranges, children 0-6 years category comprised the highest age percentage of abuse (42%). Sexual abuse was the highest (53%) abuse or neglect problem and the alleged abusers were most often parents or stepparents (43%).	
20. DCJS should promote and assist localities in establishing SARTs throughout the Commonwealth by providing funding for the teams, establishing and disseminating model protocols, and by providing training in SART services in local communities. It is recommended that an amendment be added to §*9.1-102* of *the Code of Virginia* which directs DCJS to establish training standards and publish a model policy and protocols for local and regional sexual assault response teams.	A person reporting a sexual assault may encounter three systems-criminal justice, healthcare and advocacy (victims' services). A SART is a very specific intervention model, offering an immediate response to reports made by victims of sexual assault. This comprehensive and coordinated intervention approach intentionally focuses on the sensitive needs of sexual assault victims. Virginia has fewer than 10 localities that have active adult sexual assault response teams and fewer than five of these teams have written protocols. Five to 10 localities in Virginia are in the process of organizing SARTs in their localities. Attempts have been made to support SART teams with grant funds. However, there is not enough grant funding available to support teams throughout the Commonwealth. Rural localities have been unable to support the costs of teams.	One FTE at DCJS: $89,651 Partner Meetings: $12,000 Training Programs: $26,250 Local SART Programs: $1,961,000 Total: $2,088,901
21. The Secretary of Health and Human Resources, Secretary of Public Safety, DCJS, Supreme Court and the Commonwealth's Attorneys' Services	*§19.2-11.2* prohibits law enforcement agencies from disclosing information, which directly or indirectly identifies the victim of sexual violence. However, the names of sexual violence victims and their personal information are sometimes accessible through public	Minimal - Work can be accomplished with existing staff.

Treatment and Intervention		
Recommendation	**Explanation**	**Cost & Comments**
Council should work in partnership to establish clear protocols and procedures regarding access to a victim's records to protect the privacy of sexual assault victims. The *Code of Virginia* should establish clear protocols that address proper access, use and public availability of medical and mental health records, documentation of law enforcement investigations (including closed investigations) and court proceedings and decisions related to the victim.	searches of legal records usually after a case is closed. Victims should have assurance that their identity and personal information are safeguarded.	
22. The Virginia Department of Health Professions should establish a certification for therapists working with child and adult victims of sexual violence.	The Commonwealth currently requires therapists working with sex offenders to be certified. Providing a certification for licensed therapists working with sexual assault victims will help victims who are seeking sexual assault counseling in identifying appropriate service providers.	Work can be accomplished with existing staff.
23. The General Assembly should increase funding for sexual assault crisis centers to meet the need identified by DCJS for adequate crisis services throughout the state.	In order to continue to provide both core (e.g. crisis intervention) and comprehensive (e.g. long-term therapy) services to victims of sexual violence, Virginia's Sexual Assault Crisis Centers (SACCs) need additional funding. DCJS estimates that an additional $2.3 million annually is required for this purpose. DCJS estimates $2.3 million based on the average number of sexual violence victims who report the crimes to law enforcement officers in Virginia, an average reporting rate, the average number of victims served by SACCs, and the average total amount funded annually. Using these numbers, DCJS estimates that approximately 8,145 victims in Virginia are not currently receiving services, and that it will cost an additional $2.3 million to bridge that service gap.	$2.3 million per year

Treatment and Intervention		
Recommendation	**Explanation**	**Cost & Comments**
24. VDH should expand Project RADAR to include screening for sexual violence. VDH and the VSDVAA should collaborate with professional organizations, such as the Virginia Hospital and Health Care Association, the Virginia Chapter of the International Association of Forensic Nurses and the Medical Society of Virginia, to raise awareness of sexual assault as a health care issue with health care personnel, in particular those in primary care practices and emergency departments.	Survey data collected from Virginia's Emergency Departments (EDs) and Primary Medical Practices indicates a significant need for provider training and health policy initiatives on sexual violence. As cited in the legislative report, Response to and Prevention of Sexual Violence in the Commonwealth of Virginia (2005), less than half of Virginia's emergency medical staff receive training on sexual assault or rape upon hire, and 71% of EDs do not have a standardized screening protocol in place. Nearly half (46%) of EDs do not have a formal treatment plan for sexual assault victims, and most do not work collaboratively with their local sexual assault programs or utilize available services. The need for training and education in primary medical practices is even more apparent, with only 13% of practices using a standardized screening instrument and 89% reporting that they do not have any staff members trained to assist sexual assault victims. Project RADAR [28], a training and policy initiative implemented by VDH two years ago, was developed to assist healthcare providers to most effectively identify, assess and manage patients experiencing domestic violence, but only addresses sexual violence to the extent that it occurs as a form of partner abuse. This recommendation would expand Project RADAR to all sexual violence victims.	$200,000 per year
25. The Commonwealth should fund basic V/W program services statewide and target localities documented to have the highest need for these services.	DCJS' latest V/W Staffing Needs Assessment indicates that the top 10 most understaffed local programs need 38 additional FTE positions. No new local staff positions have been supported with DCJS grant funds since July 2002 and annual grant awards have been level for three fiscal years. Additionally, four localities (Buckingham, Nottoway, Rappahannock, and Richmond Counties) do not have V/W Programs. Federal and state special funds available to support grant funded V/W Programs have declined in the past few years. In recognition of the	$2 million per year

28 **R**outinely inquire about present and past violence, **A**sk direct questions, **D**ocument findings, **A**ssess safety, **R**eview options and referrals

Treatment and Intervention		
Recommendation	**Explanation**	**Cost & Comments**
	need to maintain the level of funding for current grant programs, the General Assembly, in 2007, appropriated $3.1 million in General Funds to supplement federal and state special funds supporting these programs. Recent analysis of available revenue, expenditures and obligations suggest that the current appropriation level may not be sufficient to maintain level funding of programs for a fourth straight year, and certainly is insufficient to support additional staff or new programs. The requested $2 million increase in General Funds would support the addition of approximately 30 FTE's in understaffed local V/W Programs, especially in underserved urban and suburban areas of the Commonwealth. Without the appropriation of $2 million, it is estimated annually 8,516 victims will not receive program services annually. This estimate includes 522 victims of sexual assault or abuse.	
26. The United States Congress should pass legislation to raise or eliminate current funding limitations established by the federal Victims of Crimes Act (VOCA). Congress should increase the FY 2008 cap on Crime Victims Fund to at least $661 million in order to restore funding for state victim assistance formula grants to the same amount as in FY 2006.	Congress passed the Victims of Crime Act (VOCA) in 1984. This Act created the VOCA fund, a federal source for funding victim assistance programs and services. Federal VOCA funds are used to provide services to victims of crime. All of the money used for VOCA programs comes from various federal criminal fines, forfeitures, assessments and penalties. None of the money used by VOCA comes from taxpayer appropriations. In Virginia, VOCA funds are administered on the state level by the Criminal Injuries Compensation Fund (CICF) and DCJS. DCJS transfers a portion of VOCA funds to the Virginia Department of Social Services (DSS). CICF uses VOCA compensation funds to support victims' compensation claims, which provide funds to help victims cope with the costs associated with the crimes committed against them, such as medical expenses, time lost from work and counseling. DCJS uses	None.

Treatment and Intervention		
Recommendation	**Explanation**	**Cost & Comments**
	VOCA assistance funds to support sexual assault crisis centers and to support local and state victim/witness programs. DSS uses the funds to support programs that provide services to victims of domestic violence and child abuse. Since 2000, Congress has imposed a limitation (cap) on the amount of the Crime Victims Fund that can be obligated and distributed to states each year. The FY 2007 VOCA cap reduced state VOCA assistance grants by $25.4 million. A proposed FY 2008 VOCA cap of $625 million will mean another cut of $8.8 million. State VOCA assistance grants will have lost a total of $34.2 million since FY 2006. (This amount does not reflect the ongoing need to serve more victims, provide additional services, increased operating costs or the cost of keeping pace with inflation.) Recent legislative efforts have focused on increasing the VOCA cap so that it is at least $661 million in order to restore the FY 2006 level of funding for state VOCA victim assistance grants.	
27. The Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) should ensure that local Community Service Boards (CSBs) provide services to child victims of sexual violence.	CSBs serve as the single point of entry for the provision of mental health, mental retardation and substance abuse services in Virginia's communities. CSBs are not currently required to provide services to child victims of sexual violence. DSS estimates that 7,000 children statewide are victims of sexual abuse each year. Funds are needed to conduct victim evaluations and provide evidence-based treatment.	$3 million per year

Appendix A

Executive Order 38
Establishing the Commission on Sexual Violence

Importance of the Issue

The General Assembly and this administration took giant steps to develop important legislative and budgetary initiatives to manage sexually violent predators. While these efforts may prevent future crimes, the same level of energy and attention needs to be focused on the treatment of current victims of sexual violence and the prevention of future acts.

Sexually violent predators represent only a small minority of offenders and, given the physical and emotional trauma experienced by victims of sexual violence, research indicates that the vast majority of sexually violent acts are never reported.

Additional investigation of initiatives to support sexual violence prevention activities and comprehensive services to crime victims is essential and complementary to the recent efforts to manage perpetrators. This would further ensure the safety and health of citizens of the Commonwealth.

Accordingly, in this order I establish a Governor's Commission on Sexual Violence.

Establishment of the Commission

While many localities have taken voluntary steps to address sexual violence within their communities, additional tools and resources are needed. Accordingly, based on the consultation with and the best professional advice from the Secretaries of Health and Human Resources and Public Safety, I am hereby formally establishing the Governor's Commission on Sexual Violence, to improve the treatment of crime victims with emphasis on the Commonwealth's efforts to prevent and respond to sexual violence.

This Commission, through its work, will promote: appropriate and uniform criminal justice responses to sexual violence, comprehensive services to victims and effective prevention initiatives.

Composition of the Commission

The Governor's Commission on Sexual Violence shall be co-chaired by the Secretaries of Health and Human Resources and Public Safety. Recognizing that these efforts will require the work of individuals across a broad spectrum of professions and expertise, the Commission shall consist of 38 members appointed by the Governor and serving at his pleasure. Appointees shall include representatives of state agencies, the General Assembly, advocates for victims of domestic and sexual violence, law enforcement, and health professionals. Additional members may be appointed at the Governor's discretion.

Staff support for the commission will be provided by the Secretaries of Health and Human Resources and Public Safety.

Duties of the Commission

The Commission's responsibilities shall include the following.

1. Review the recommendations set forth in Senate Document 18 (2005) and in the Sexual Violence State Plan as well as other relevant reports and studies.

2. Seek input and comment through regional public hearings to gather information.

3. Design strategies for implementing recommendations from these sources, including prioritization, approach, timeline, and designation of duties to accomplish the Commission’s stated purposes of preventing and responding to sexual violence.

4. Design strategies to institutionalize recommendations into practice across Virginia.

5. Make any other recommendations as may be appropriate.

The Commission shall make an interim report of its activities by September 30, 2007. At that time, I will consider the need to review the commission for an additional year.

Effective Date of the Executive Order

This Executive Order shall be effective October 10, 2006, and shall remain in full force and effect until October 10, 2007 unless amended or rescinded by a further Executive Order.

Given under my hand and under the Seal of the Commonwealth of Virginia, this 10th day of October 2006.

/s/ Timothy M. Kaine, Governor

Attest:

/s/ Secretary of the Commonwealth

Appendix B

Governor Kaine's Commission on Sexual Violence Commission Members

Co-chairs

The Honorable John W. Marshall
Secretary of Public Safety

The Honorable Marilyn Tavenner
Secretary of Health and Human Resources

Members

Grace Albano-Orsini
Samaritan House

The Honorable Cassandra Burns
Commonwealth's Attorney, Petersburg

Anthony Conyers, Jr.
Department of Social Services

Leonard Cooke
Department of Criminal Justice Services

Susan Curtis
Loudoun Abused Women's Shelter

D. Gay Cutchin
Virginia Commonwealth University

Carroll Ann Ellis
Fairfax County Police Department

Colonel W. Steven Flaherty
Virginia State Police

The Honorable H. Morgan Griffith
Virginia House of Delegates

Robert Harris
Commonwealth's Attorneys' Services Council

Linda Heatwole
Rockingham Memorial Hospital

The Honorable R. Edward Houck
Senate of Virginia

The Honorable Janet Howell
Senate of Virginia

Rita Katzman
Child Protective Services

Charles Lineberg
Citizen of the Commonwealth

Chief Michael Marshall
Virginia Miliatary Institute

The Honorable Jennifer McClellan
Virginia House of Delegates

The Honorable Robert McDonnell
Office of the Attorney General

Cherri Murphy
Charlottesville Victim/Witness Office

Eric Olson
Polygraph Examiners Advisory Board

Bonnie Price, RN, BSN, SANE-A/P
St. Mary's Hospital

Cristina Rebeil
Virginia Poverty Law Center

The Honorable Angela Roberts
Richmond Juvenile and Domestic Relations Court

The Honorable Stephen Shannon
Virginia House of Delegates

Reverend C. Douglas Smith
Virginia Interfaith Center for Public Policy

Robert Stroube, M.D.
Virginia Department of Health

Susheela Varky, Esq.
Office of the Executive Secretary, Supreme Court of Virginia

The Honorable Vivian Watts
Virginia House of Delegates

The Honorable Fred Newman
Washington County Sheriff's Office

Stacey Plichta, Sc.D.
Old Dominion University

The Honorable Linda Puller
Senate of Virginia

James Reinhard, M.D.
Deparment of Mental Health, Mental Retardation and Substance Abuse Services

Dana Schrad
Virginia Association of Chiefs of Police

The Honorable Beverly Sherwood
Virginia House of Delegates

The Honorable Kenneth Stolle
Senate of Virginia

DaShawnna Townsend
Center for Sexual Assault Survivors

Mary Vail Ware
Criminal Injuries Compensation Fund

Appendix C

Governor Kaine's Commission on Sexual Violence
Interagency Core Workgroup Members

Co-Chairs

Marilyn Harris
Deputy Secretary of Public Safety

Gail Jaspen
Deputy Secretary of Health and Human Resources

Members

Greg Brittingham
Virginia Commonwealth University

Erin Bryant
Secretary of Public Safety's Office

Fran Ecker
Department of Criminal Justice Services

Robert Franklin
Virginia Department of Health

Nancy Fowler
Department of Social Services

Fran Inge
Family and Children's Trust Fund
Department of Social Services

Rebecca Odor
Virginia Department of Health

Mandie Patterson
Department of Criminal Justice Services

Felix Sarfo-Kantanka
Governor's Policy Office

Dr. Steven Wolf
Department of Mental Health Mental Retardation and Substance Abuse Services

Appendix D

Governor Kaine's Commission on Sexual Violence Committee Members

Criminal Justice System Committee

Chair

The Honorable Vivian Watts
Virginia House of Delegates

Vice-Chair

Fran Ecker
Department of Criminal Justice Services

Primary Staff Resource

Jane Sherman Chambers
Commonwealth's Attorney's Services Council

Additional Committee Members

Second Lt. Brenda Akre
Fairfax County Police Department

Marla Decker
Office of the Attorney General

Kristine Hall
Virginia Sexual and Domestic Violence Action Alliance

Reverend Katherine T. Gray
Citizen of the Commonwealth

Betty Jones
Women's Resource Center of the New River Valley

Anne Mitchell
King William County Department of Social Services

Scott Richeson
Virginia Department of Corrections

Captain Thomas Turner
Virginia State Police

Additional Staff Resources

Nancy Fowler
Department of Social Services

Fran Inge
Department of Social Services

Prevention Committee Members

Chair

The Honorable Linda Puller
Senate of Virginia

Vice-Chair

Johanna Schuchert
Prevent Child Abuse Virginia

Primary Staff Resource

Rebecca Odor
Department of Health

Additional Committee Members

Gianna Gargieletti
Citizens Against Sexual Assault

Vicki Mistr, Ph.D.
Virginia Correctional Center for Women

Joyce Moran
Children's Advocacy Programs of the Blue Ridge, Inc., Southern VA Child Advocacy Center

Nancy Oglesby
Deputy Commonwealth's Attorney

Kristi Van Audenhove
Virginia Sexual and Domestic Violence Action Alliance

Additional Staff Resources

Robert Franklin
Department of Health

Treatment and Intervention Committee Members

Chair

The Honorable Stephen Shannon
Virginia House of Delegates

Vice-Chair

Ruth Micklem
Virginia Sexual and Domestic Violence Action Alliance

Primary Staff Resource

Mandie Patterson
Department of Criminal Justice Services

Additional Committee Members

Susan Carson
VCU Health System

Dr. Jane Hollingsworth
Children's Hospital of the King's Daughters

Lisa Parks
Lynchburg Department of Social Services

Ellen Yackel
The Haven Shelter and Services

Detective Sandra Hein
Alexandria Police Department

Eric L. Olsen
Deputy Commonwealth's Attorney

Sandy Rasnake
Bristol Crisis Center

Additional Staff Resources

Felix Sarfo-Kantanka
Governor's Policy Office

Dr. Steven Wolf
Department of Mental Health, Mental Retardation and Substance Abuse Services